Australian Government
Department of Health

phn
An Australian Government Initiative

Activity Work Plan 2018-2021:
Integrated Team Care Funding

The Activity Work Plan template has the following parts:

1. The Integrated Team Care Annual Plan 2018-2021 which will provide:
    a) The strategic vision of your PHN for achieving the ITC objectives.
    b) A description of planned activities funded by Integrated Team Care funding under the Indigenous Australians' Health Programme (IAHP) Schedule.
2. The Budget for Integrated Team Care funding for 2018-2021 (attach an excel spreadsheet using template provided).

Western NSW PHN

When submitted this Activity Work Plan 2018-2021 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

The Activity Work Plan must be lodged to your Program Officer via email on or before four (4) weeks after the execution of the Integrated Team Care Funding Schedule Deed of Variation.

Overview

This updated Activity Work Plan covers the period from 1 July 2018 to 30 June 2021. To assist with PHN planning, each new activity nominated in this work plan should be proposed for a period for 12 months.

1. (a) Strategic Vision for Integrated Team Care Funding

Western Health Alliance Limited (WHAL) which operates Western NSW Primary Health Network (WNSW PHN) is committed to the vision that sees Integrated Team Care (ITC) being premised under a Consortium model grounded in the context of unique Aboriginal Health partnerships that focus on improving poor health. The concept proposes that solutions to lift Aboriginal Health will be driven through Aboriginal-owned General Practice clinics and services, and through the spread of integrated health, social and cultural capacity across mainstream General Practice and primary care networks.

A key strategic priority for the WNSW PHN is to:

Work in partnership to improve Aboriginal and Torres Strait Islander health outcomes

This will be achieved by:

i. Strengthening partnerships and working in collaboration across the Aboriginal health sector

- Working in collaboration with Aboriginal health partners, which are the foundations of the WNSW PHN, through the Aboriginal Health Council.

ii. Working in partnership with the Aboriginal health sector and primary care services to improve health outcomes and access for Aboriginal and Torres Strait Islander people with Chronic Disease.

- Supporting Aboriginal Community Health Services spread the delivery of innovative, high performing Aboriginal health services across all communities in our WNSW PHN region.

iii. Supporting culturally safe models of care and programs

- Supporting Aboriginal communities and service providers in those communities to increase Aboriginal ownership of health services, empower and self-navigate toward improved health outcomes.

The WNSW PHN's proposed approach to Integrated Team Care will focus working in collaboration with the Aboriginal Community Controlled Health Organisations (ACCHOs) in the region to improve health outcomes for Aboriginal and Torres Strait Islander people. This approach aligns with what has been identified at both a state and national level, in regard to the significance of Aboriginal and Torres Strait Islander peoples (ATSI) participation in and control of primary health care services as an effective action to improve health outcomes for ATSI people.

The vision of collaboration with ACCHOs closely compliments the ITC objectives specifically improving the treatment and management for Aboriginal and Torres Strait Islander people with chronic disease conditions. It also extends to fostering collaboration and support between the mainstream primary care and the Aboriginal and Torres Strait Islander health sectors.

WNSW PHN through the establishment of its Aboriginal Health Council guarantees Indigenous community involvement in the planning, management and delivery of local primary health care services, in this case the ITC program. The WNSW PHN therefore embeds a committed imprint toward closing the gap in health outcomes between ATSI people and other Australians and also shaping dedicated links with the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.

Using ACCHOs to provide the chronic disease brokerage service permits the practical benefit of decreasing the overhead costs associated with the ITC program through a more effective sharing of resources resulting in an increase in the investment in frontline services.

A key outcome of the Single Provider or Most Capable Provider (MCP) Approach, based on goals and outcomes agreed between WNSW PHN and ACCHOs, will be closer collaboration and support between mainstream primary care providers and the ATSI Islander health sectors. Additionally, there will be a requirement for linkages with the two Local Health Districts (LHDs) in the region, particularly through the Integrated Care Strategy demonstrator sites.

1. (b) Planned activities funded by the Indigenous Australians' Health Program Schedule for Integrated Team Care Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2018-2021. These activities will be funded under the IAHP Schedule for Integrated Team Care.

Public Accountability	
What are the sensitive components of the PHN's Annual Plan? Please list	*List the Annual Plan components that the PHN considers sensitive and does not wish to upload onto its website. With the exception of Budget information, the department assumes anything that is not listed here will be uploaded by the PHN onto its website, after the Activity Work Plan is approved by the department.*

Proposed Activities - copy and complete the table as many times as necessary to report on each activity	
Existing, Modified, or New Activity	*Indicate if this is an existing activity, modified activity (2016-18 Activity Work Plan), or a new activity. If an existing or modified activity, provide the relevant reference/s from previous Activity Work Plan/s where possible.* Existing activity
Start date of ITC activity as fully commissioned	The WHAL authority master agreement for ITC was signed 15 October 2016 with Maari Ma Health Aboriginal Corporation (Maari Ma Health) . WNSW PHN ITC program, a brokerage service delivery model for chronic disease commenced on November 1, 2016. 'Marrabinya' which comes from the Wiradjuri language and means 'hand outstretch thee' is the name of WNSW PHN Indigenous Health Support Service (IHSS).
Is the PHN working with other organisations and/or pooling resources for ITC? If so, how has this been managed?	The WNSW PHN works with many organisations in delivering this unique of ITC and a key feature is strong Indigenous partnership alliances. Some core affiliations are with; the WNSW PHN Aboriginal Health Council, several ACCHOs across the WNSW PHN footprint area, the Western Local Health District (NSW Health) integrated care strategy program staff and also Bila Muuji Aboriginal Health Services Incorporated, the regions peak ACCHO/AMS consortium group. Management of these partnerships involves attendance and collaboration at meetings, regular provider and program updates (to the WNSW PHN Aboriginal Health Council) and Project monitoring i.e. PHN reporting and evaluation, Stakeholder, patient and GP feedback and program governance. The Marrabinya Governance Group, a sub-committee of Maari Ma Health and the Bila Muuji consortia membership is another important input to the ITC program. This group provides strategic level advice to inform: • Commissioning and provider engagement linked to the model, program outcomes and planning beyond the 2017/18 contract. • Strategies to engage ACCHO and mainstream general practice

	• Community engagement strategies to ensure Aboriginal people eligible for services under the program are accessing the service. • Managing community expectations. The Marrabinya Governance Group reviews bi-monthly progress reports, including outputs, risks and key issues that have the potential to impact on the Maari Ma / Bila Muuji Alliance and Marrabinya reputation with regards to delivering on the ITC contract.
Service delivery and commissioning arrangements	**WNSW PHN plans to extend the contract with the current ITC service provider Maari Ma Health Aboriginal Corporation (Maari Ma Health).** <u>Background</u> The program was commenced on 1 November 2016 using a single/most capable provider (MCP) approach to Maari Ma Health in Broken Hill and the approach extended the reach of that ACCHO to provide health services for Aboriginal people beyond the local communities in the far west region of NSW to cover around half of the NSW area. 'Marrabinya' which comes from the Wiradjuri language and means 'hand outstretch thee' is the name of WNSW PHN Indigenous Health Support Service (IHSS) and the service delivery model for ITC was developed in partnership with peak Aboriginal consortium groups in the WNSW PHN region. Under the auspice of Maari Ma Health, IHSS delivers ITC services through an Aboriginal consortium led brokerage service model which permits the ACCHO the practical benefit of decreasing the overhead costs associated with the ITC program through a more effective sharing of resources resulting in an increase in the investment in patient services i.e. savings through co-locating staff within various consortium member Aboriginal Medical Services and related organisations, sharing office space, administrative support and other workforce assets, and diverting those savings to service provision. <u>Key uniform factors that underpin the IHSS service delivery model objective in WNSW:</u> 1) GP and Aboriginal Patient centred ITC health services 2) General Practice and Patient led Chronic disease care 3) Aboriginal patient empowerment through strengthened GP and Patient engagement and 4) Reduced service duplication Care coordination (CC) in the WNSW PHN model • One on one Patient CC is not provided under the WNSW PHN ITC model and Patient CC is instead located in and undertaken by the patient's referring general practice (health care home) *in alignment to WNSW PHN IHSS service delivery model objective. • Patient CC activities have been replaced by Program/Service CC activities and include for example: engaging with general practice, AMSs and referring GPs to educate and promote the brokerage service model and assist with cultural safety and competency advice and education. Additionally to support activities that focus on

	strengthening Practice led Patient health care coordination and increase the capacity of Aboriginal patients to self-manage their own Chronic health care. <u>Referral process in the WNSW PHN model</u> Indigenous patients must be enrolled for chronic disease management in a general practice or an Aboriginal Community Controlled Health Organisation (ACCHO). **Step 1** GP completes ATSI health check (715). **Step 2** GP completes GP management plan (721). **Step 3** GP assesses the patient's needs for extra services and refers an eligible patient to Marrabinya (IHSS) to arrange / purchase the extra services. (A central phone number and direct email contact has been communicated to all mainstream health providers and AMSs). **Step 4** IHSS reviews the referral. If accepted, an Outreach worker (Local Chronic Care Link Worker) is assigned to follow-up with the patient and referring doctor. <u>Operational components in the WNSW PHN model</u> Working collectively to improve patient outcomes, GPs with an Aboriginal patient eligible for the ITC program who have a current GPMP or patients themselves, link into the program via direct referral to the 1800 number that connects them to program intake. The coordination manager (IHPO) then assesses patient support service requirements and allocates the patient service follow-up to the Chronic Care Link workers (Outreach Workers). The focus of the WNSW PHN model is on organising schedule planned care in advance and a minimum of 48 hours' notice is required for IHSS to review, assess, respond to referrals and arrange/purchase agreed services. IHSS is not set up to address crisis/acute issues and GPs should utilise Enhanced Primary Care (EPC) items in the first instance to refer patients for allied health services and refer to IHSS only after exhausting EPC appointments. The emphasis of the new IHSS brokerage service model supports the patient care provided by the patient's GP in both General Practices and Aboriginal Medical Services. The IHSS brokerage service is not a parallel clinical service and is intended to be seen in the first instance as a program for last resort after all alternative programs have been exhausted so as to avoid undue duplication service and patient expenditure. In practice, IHSS liaise between the client's primary care provider (e.g. GP or AMS), the client and also the service, as per the patient care plan that the clients need. Feedback is then provided to the GP or AMS who continues to be the primary manager responsible for direct client/patient care. The brokerage service that IHSS provides thus facilitates the client receiving the care that is deemed necessary by their GP according to their care plan and promotes clinical care being provided by the GP to prevent disconnected patient information and service delivery, and promote better integrated and patient centred-care. IHSS provides support to both mainstream health providers and Aboriginal community controlled sectors to ensure patient access to a comprehensive

	array of services for example; Gap fees associated with health appointments such as diagnostic tests, specialist appointments; Travel and accommodation to attend health appointments; Webster packs for patients with poly pharmacy; Assisted breathing equipment; Oxygen; Medical footwear prescribed and fitted by a podiatrist. * services provided are documented in the patient's GPMP and are not available under other programs. IHSS regularly consults with various Aboriginal community groups and supported by various consortium group partners, also regularly presents and workshops the brokerage model to Aboriginal Health staff, Aboriginal community groups, mainstream and AMS general practice, patients as well as to related sector partners as well.
Decommissioning	NA
Decision framework	The decision framework for the WNSW PHN ITC project is founded in the literature that informs factor significant health disadvantage for Aboriginal people. Indigenous Australians experience disproportionate levels of educational, employment and social disadvantage and unacceptably many Indigenous Australians also experience poorer health than other Australians, often dying at much younger ages. Using an evidence-based framework, through ITC the WNSW PHN aims to continue to address the pressing social inequality and determinants of health that are so pivotal to long term health improvements most particularly for Aboriginal people in WNSW PHN Aboriginal communities. The following information is outlined in the WNSW PHN Needs Assessment 2016 and accordingly, it informs the WNSW PHN needs assessment outcomes in relation to identifying Aboriginal Health and inclusive and proposed effective partnerships with Aboriginal communities as a key priority. In relation to ITC, this included the re-designed model that is now implemented through the WNSW PHN region. • WNSW PHN has the highest Aboriginal population (10.5.%) of all NSW PHNs (ABS, 2017). • For residents of WNSW PHN, 40.7% of respondents aged 15+ yrs. were current daily smokers; 59.5% of participants aged 2 yrs. and over were overweight or obese; and 76.7% have at least one long term health condition. (2012-13 National Aboriginal and Torres Strait Islander Health Survey -ABS). Other significant influences linked to the ITC decision framework include the WNSW PHN's Aboriginal Health Council that continues to support and advise the WHAL Board on strategic directions and opportunities to improve the health and wellbeing of Aboriginal people living in Western NSW. The Aboriginal Health Council's role confirms the strategic intent of the WNSW PHN to build innovation and collaboration with the ACCHOs sector, to assist the development of a locally responsive patient centred system of primary health care that will deliver better outcomes for the communities of the Western region and specifically recognise the needs of Aboriginal people. This council has continued involvement and in the provision of

	advice to the WHAL Board and WNSW PHN Management on the future direction of the ITC program. Additionally, 'What works' in partnering to deliver effective Aboriginal health services The Western New South Wales Primary Health Network experience, Deeble evidence brief no: 15, 23 August 2017 outlines and discusses the WNSW PHN arrangements and how they are supporting and building a stronger platform for the delivery of Aboriginal primary healthcare services in this region. Early evidence is suggesting that the partnership between WNSW PHN and Aboriginal primary healthcare services in the Western NSW PHN region is proving effective in terms of increased trust and supporting a stronger network of services for local Aboriginal communities. In particular; Part 1: The Australian experience to date on what works generally—the main characteristics of successful Aboriginal health policies and programs aimed at overcoming Indigenous disadvantage. Part 2: The Western NSW PHN and its approach—a profile of the PHN region and how the PHN has embedded Aboriginal Health as its top healthcare priority, structurally and practically. This is explored with particular reference to the PHN's commissioning and funding of the 'Marrabinya' ITC program—how it was established, how it works, and evidence of results so far.
Indigenous sector engagement	A key feature of the program is strong Indigenous partnership alliances and therefore a strong commitment to ongoing engagement with the Indigenous health sector. Some of the core WNSW PHN Indigenous affiliations are with; the WNSW PHN Aboriginal Health Council, many of the ACCHOs across the WNSW PHN footprint area, Regional local Health District Aboriginal health workers (NSW Health), Bila Muuji Aboriginal Health Services Incorporated, the regions peak ACCHO/AMS consortium group, the two Aboriginal reginal assembly alliance groups and also various other Aboriginal stakeholder organisations such as Aboriginal lands council groups. Management strategies for maintaining these partnerships and a commitment to ongoing engagement involves network co-operation, attendance and collaboration at meetings, regular provider and program updates (to the WNSW PHN Aboriginal Health Council) and Project monitoring review i.e. PHN reporting and evaluation, Stakeholder, patient and GP feedback and program governance. Such is the commitment for ongoing engagement with the Indigenous health sector, that it is the intention of WNSW PHN to formalise and strengthen its indigenous partnerships and sector alliances by incorporating MOUs and partnerships TORs at s strategic level within an WNSW PHN Aboriginal Engagement Framework, yet to be developed but with work to commence in 2018/19.
Decision framework documentation	The ITC decision framework adopted by WNSW PHN originates in the successful application to operate the WNSW PHN. Drawing a similar parallel, the founding documents submitted by a consortium in January 2015, proposed that "solutions to lift Aboriginal Health will be driven through Aboriginal-owned General Practice clinics and services, and through the

	spread of integrated health, social, and cultural capacity across mainstream General Practice and primary care networks". Additional to the founding WNSW PHN documentation, other decision framework documentation for ITC includes; I. WNSW Primary Health Network's Strategic Plan II. WNSW Primary Health Network Needs Assessment, 2016 III. WNSW Primary Health Network Mental Health and Drug & Alcohol Needs Assessment, 2016 IV. WNSW PHN Regional Health Profile
Description of ITC Activity	ITC services provided to patients by Maari Ma through IHSS as the current ITC provider under the new brokerage service model commenced on November 1, 2016. A minimum of 20 episodes of care per day under the new brokerage service model has been delivered to clients where services are documented as a need in the patient's GPMP and where they are not available under other programs with access to the ITC program being chiefly via the referral process: **Step 1** GP completes ATSI health check (715). **Step 2** GP completes GP management plan (721). **Step 3** GP assesses the patient's needs for extra services and refers an eligible patient to Marrabinya (IHSS) to arrange / purchase the extra services. (A central phone number and direct email contact has been communicated to all mainstream health providers and AMSs) **Step 4** IHSS reviews the referral. If accepted, an Outreach worker (Local Chronic Care Link Worker) is assigned to follow-up with the patient and referring doctor. Since January 2018 a new and more detailed reporting regime has been in place. This includes general practice feedback and patient / client feedback. We expect that this will inform us of the care coordination aspects of the model and where the outcome shows a care coordination gap both the provider and Western NSW PHN will be able to address this. Marrabinya receives a referral from a client's GP, requesting the components of care that are required to support that person and their chronic disease management: specialist appoint, webster pack, etc. By preparing and sending the referral with a GPMP in place, the practice is demonstrating that care coordination is underway. Marranbinya's job is to be the machinery to make those components happen and for the information to go back to the GP for the ongoing coordination. This model is safer than care coordination being outsourced to a third party and separated from the patients home based practice. The usual treating GP (and patient) is in the driver's seat and the referring practice takes on responsibility for coordinating care as outlined in the GPMP. An independent evaluation of WNSW PHN's commissioned ITC program will be conducted in 2018/19 to review the outcomes of the program, and the

	service model. This evaluation will apply best-practice methodology and focus on quadruple aim outcomes. An independent evaluator with relevant experience will be engaged as consultants for this work.
ITC Workforce	IHSS delivers ITC in seven cluster areas across the 53% of NSW that the WNSW PHN covers. Workforce flexibility has been applied in relation to the form the ITC roles will take in individual communities, based on need, whether the roles will be located in a General Practice/ ACCHO, and workforce availability. The consortium based agreement of using ACCHOs to provide the chronic disease brokerage service utilising partners resources e.g. the premises to locate the ITC care link workers, permits the practical benefit of decreasing the overhead costs associated with the ITC program through a more effective sharing of resources resulting in an increase in the investment in frontline services. ***External ITC Workforce*** <u>1FTE Program Coordinator (IHPO)</u> *located/based with AMS provider at Bourke- works across the region in each of the Cluster areas* • Key functions: Program coordination, Aboriginal Health planning and engagement, oversees the delivery of ITC services, manages intake referrals, liaises closely with WNSW PHN's IHPO through program reporting and monitoring, considerable involvement in building relationships between ACCHOs and mainstream primary health care services, colleague support and staff development, program and service data input, Aboriginal Health planning and engagement activities, presents and workshops the brokerage model to Aboriginal Health staff, Aboriginal community groups, mainstream and AMS general practice, patients as well as to related sector partners. <u>10.4x FTE + 1x 0.4 FTE Program Chronic Care Link Workers CCLW *(outreach workers)-</u> *works across the region in allocated cluster areas and located/based at various AMS's and other associated Aboriginal sector/partner organisations* - Wentworth, Broken Hill, Dubbo, Bourke, Coonamble, Condobolin, Wellington, Orange, Bathurst, Regional CNS Cowra. • Key functions: liaise between the client's primary care provider (e.g. GP or AMS), the client and also the service, as per the patient care plan that the clients need. Feedback is then provided to the GP or AMS who continues to be the primary manager responsible for direct client/patient care. The brokerage service that IHSS provides thus facilitates the client receiving the care that is deemed necessary by their GP according to their care plan and promotes clinical care being provided by the GP to prevent disconnected patient information and service delivery, promoting better integrated and patient centred-care. Patient CC activities include as a minimum: engaging with general practice, AMSs and referring GPs to educate and promote the brokerage service model and assist with cultural safety and competency advice and education and support activities that focus on strengthening Practice led Patient health care coordination and increase the capacity of Aboriginal patients to self-manage their own Chronic health care.

	Brokerage services by Care Link Workers involves assessing the referral and establishing the non-clinical aspects of the referral and putting in place arrangements to pay for fees, gap payments, travel and accommodation associated with the patient accessing the services. These workers provide feedback to the referring GP on the outcomes of the referral and GP management plan. ***Internal ITC Workforce*** 1FTE Program Manager (IHPO) *located within the WNSW PHN Dubbo office* (The justification for this relates to the significant Aboriginal population in the WNSW PHN region and the need for effective PHN coordination of primary health care services for Aboriginal people) – *works across the region*. • Key functions: Program management, Aboriginal Health planning and engagement, oversees the delivery of ITC program, Program service performance and evaluation reporting, stakeholder engagement, maintaining and extending relationships with mainstream health services and sector partners including with Bila Muuji and its AMS consortium members, cultural safety education for GPs, practice staff and allied health service providers, maintaining and strengthening collaboration between Indigenous Health providers to ensure and preserve resource sharing arrangements e.g. shared office space to locate ITC care co-ordinators, tapping into existing ACCHOs administrative support and workforce assets, colleague support and staff development, program data analysis, Aboriginal Health planning and engagement activities, presents and workshops the brokerage model to Aboriginal Health staff, Aboriginal community groups, mainstream and AMS general practice, patients as well as to related sector partners. 1FTE Program Officer located within the WNSW PHN Dubbo office, works across the region. • Key functions: to assist and provide program support to the Program Manager (IHPO) role dimensions as noted above. This role has a primary focus on implementing the WNSW PHN cultural safety framework across AMS and mainstream general practice, specialist practices and allied health provider practices to improve cultural safety in primary care services and strengthen the ITC program and health outcomes for Aboriginal people. • Included in this activity is budget for Other Project Consultants to deliver Cultural safety competence training for staff of General Practices, Specialist and Allied health practices to improve access by Aboriginal clients.